Smoking Cessation Questionnaire

Code #_____ Date_____

Age_____ Sex_____ Height_____ Weight_____

Right_____ or left_____ handed.

How long have you been smoking?_____

How did you start?_____

_____

Have you ever tried to stop? _____Yes _____No.

If yes, how many times?_____ How long?_____

How many cigarettes do you use per day (average)?_____

What brand?_____

When do you smoke the first cigarette of the day?_____

When do you smoke the last cigarette of the day?_____

How long before this recording did you last smoke?_____

Did you experience any unusual event today?_____Yes _____No

If yes, explain_____

_____

Did you experience any unusual event yesterday? _____Yes _____No

If yes, explain_____

_____

How would you judge today insofar as your performance is concerned?

above average_____ average_____ below average_____

Do you use alcoholic beverages? _____Yes _____No

If yes, could you indicate (roughly) your weekly consumption:

_____beer _____wine _____whiskey _____liquor _____other

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Age Sex Height Weight

As best you can remember, list the main illnesses up until now.

a:

Any surgical operations? Yes No. If yes, which?

When

How did you sleep last night? as usual better worse

Characterize in any way you want, what effect or effects you obtain from smoking.

Are you taking any medication either on prescription or over-the-counter, such as anti-histamines or aspirin? Yes No

If yes, which